

Case Number:	CM15-0172665		
Date Assigned:	09/14/2015	Date of Injury:	12/10/2012
Decision Date:	11/06/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/01/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 73 year old male who sustained an industrial injury on 12-10-2012. Medical records indicate that the injured worker is being treated with acute cervical strain with disc herniation, acute lumbar strain with disc herniation, acute thoracic strain with thoracic disc herniation, bilateral upper extremity sprain strain, and cervical trapezial myofasciitis, rule out C5-C6 radiculopathy. Medical record dated 7-15-2015 indicated persistent pain in the neck, lower back, left shoulder, left wrist, and hand all at a 6 out of 10. Medical records dated 2-4-2015 rated pain a 7 out of 10. Currently pain is made better with medication and rest. Pain was made worse with cold weather and activities. He was currently working. Examination of the cervical spine revealed decreased range of motion. There was tenderness to the paraspinals and hypertonicity to the trapezius muscle. Examination of the left shoulder revealed slight decreased range of motion in all planes secondary to pain and weakness. There was 4 out 5 strength. Examination of the left wrist and hand revealed decreased grip strength. There was tenderness to interosseous spaces. Examination of the lumbar spine revealed tenderness in the midline. He had tenderness and hypertonicity in the paraspinal musculature. He had asymmetric loss of range of motion. He had limited range of motion because of pain. Treatment has included medications and TENS unit since at least 3-16-2015. Utilization Review form dated 8-17-2015 non certified topical medication, tramadol, massage therapy lumbar spine, TENS unit replacement patches, 3 month extension for TENS unit rental, and consultation with a spine specialist.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Flurbiprofen/Baclofen/Lidocaine cream 20%/5%/4% 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. This patient has been diagnosed with acute strain of the thoracic and cervical spine with C5-6 radiculopathy. Per the California MTUS Chronic Pain guidelines, topical analgesics are recommended as an option and are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. This request is for a compound of flurbiprofen, baclofen and lidocaine cream. Since MTUS and the FDA do not recommend topical, compounded medications for chronic pain control, this medication is not indicated. Therefore, based on the submitted medical documentation, the request for flurbiprofen, baclofen and lidocaine cream is not medically necessary.

Tramadol 50mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, criteria for use.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. Per MTUS guidelines, "Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction." Per ODG, Tramadol is associated with an increased risk for hypoglycemia requiring hospitalization. Although rare, tramadol-induced hypoglycemia is a potentially fatal, adverse event. "Hypoglycemia adds to mounting concerns about tramadol, a weak opioid, that counter the perception that it is a safer alternative to full opioids." This patient has been diagnosed with acute strain of the thoracic and cervical spine with C5-6 radiculopathy. The patient is at risk for addiction due to his history of opioid use for chronic pain control. Therefore, based on the submitted medical documentation, the request for tramadol is not medically necessary.

Massage Therapy 2 times a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Massage Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Per California MTUS Chronic Pain Treatment Guidelines, massage therapy, "Treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." This patient has been diagnosed with acute strain of the thoracic and cervical spine with C5-6 radiculopathy. In this case, the treating physician has asked for 2 sessions a week over 4 weeks (8 total sessions of massage therapy) which exceeds MTUS guidelines. Therefore, based on the submitted medical documentation, the request for massage therapy is not medically necessary.

TENS unit replacement patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed" A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial 3. Other ongoing pain treatment should also be documented during the trial period including medication usage 4. A treatment plan including the specific short- and long- term goals of treatment with the TENS unit should be submitted 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted that indicated the patient has a quantifiable number of treatments administered, pain scales or objective evidence of clinical improvement. Although the patient reported the unit to be beneficial, objective evidence of clinical improvement and efficacy must be submitted to justify further use of the device. Therefore, based on the submitted medical documentation, the request for TENS unit replacement patches is not medically necessary.

3 Month extension for TENS unit rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed" A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial 3. Other ongoing pain treatment should also be documented during the trial period including medication usage 4. A treatment plan including the specific short- and long- term goals of treatment with the TENS unit should be submitted 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted that indicated the patient has a quantifiable number of treatments administered, pain scales or objective evidence of clinical improvement. Although the patient reported the unit to be beneficial, objective evidence of clinical improvement and efficacy must be submitted to justify further use of the device. Therefore, based on the submitted medical documentation, the request for TENS unit 3 month extension is not medically necessary.

Consultation with spine specialist: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Assessment, Follow-up Visits, Special Studies, Surgical Considerations.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a spine specialist consultation for this patient. The clinical records submitted do not support the fact that this patient has been documented to have recent spinal disease requiring consultation. The California MTUS guidelines address the issue of consultants for back and neck related pain by stating: "If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps." This patient has been documented to have a limited range of motion on physical exam due to pain. Neuropathy and or radiculopathy is not objectively documented. Imaging studies do not correlate with the patient's clinical symptomatology to indicate a cause secondary to spinal disease. Physical signs of acute tissue insult or nerve impairment are not documented. Therefore, based on the submitted medical documentation, the request for spine specialist consultation is not medically necessary.